



Napoli SURGERY

NAPOLI 27 – 28 SETTEMBRE

Aula Magna Scuola di Medicina di Scampia
Centro Congressi Università degli Studi di Napoli Federico II
Via Valerio Verbano Snc, Scampia - Napoli



CON IL PATROCINIO DI:



INDICAZIONI ALLE STOMIE IN ELEZIONE ED URGENZA

Dott. G. Marte

PO Ospedale del mare

UOC Chirurgia Generale e d'Urgenza

Dir. Dott. M.F. Armellino

NAPOLI SURGERY, 27,28 SETTEMBRE 2023

History of surgery: the evolution of views on the formation of intestinal stoma

Nikolay N. Krylov

History of Medicine, 2019, 6(2): 111–117

DOI: 10.17720/2409-5834.v6.2.2019.07g

Surgeon	Year	Pathology	Surgical procedure	Stage
Caelius Aurelianus (cited Praxagoras (the 4th century B.C.))	2nd century B.C.	Intestinal obstruction	Sovrapubic incision and bowel evacuation	First stage: realization of the possibility of excretion of faeces
Jean Méry (Hotel Dieu, Paris)	1701	Strangulated hernia	«anus contre nature»	
Alexis Littré	1710	Imperforate anus	Suggested intestinal stoma	
Queen of Great Britain, Caroline of Brandenburg-Ansbach	1737	Rupture of strangulated umbilical hernia	«Royal stoma»	Second stage: fatalism replaced by active tactics
H. Pillore	1776	Obstructive rectal cancer	First ever cecostomy	
A. Dubois	1783	Imperforate anus	unsuccessfully attempted to realise Littré's idea	
C. Duret	1793	Imperforate anus	colostomy in the left iliac region of a four-day-old infant	
P. Fine (Geneva)	1797	Obstructive rectosigmoid tumor	Double-barrel colostomy	

History of surgery: the evolution of views on the formation of intestinal stoma

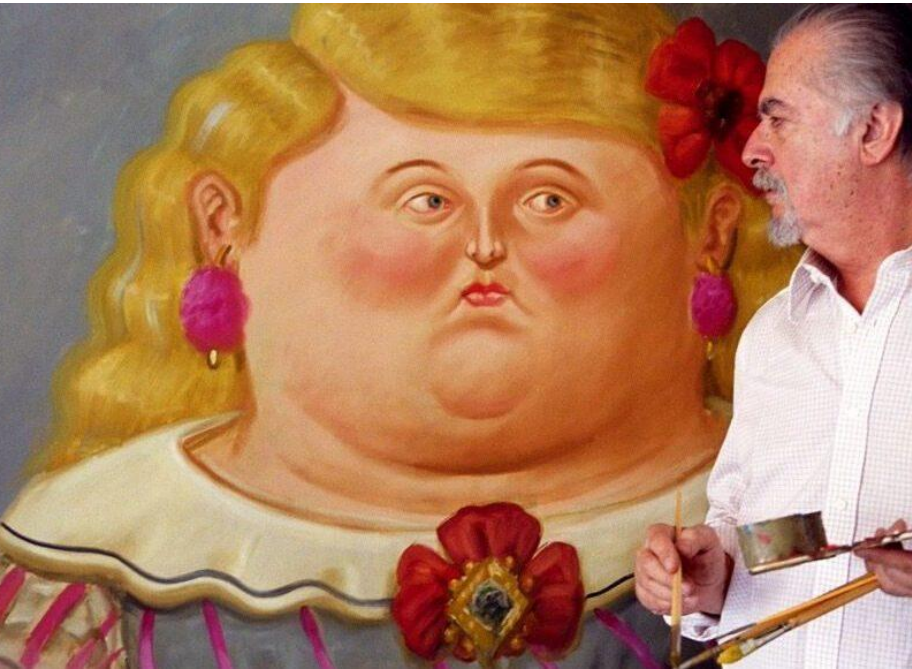
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Surgeon	Year	Pathology	Surgical procedure	Stage
T. Billroth	1879	Obstructive colon tumor	Colon resection with end colostomy	Third stage: the search for the optimal localization of intestinal stoma and expansion of indications for it
O. Madelung	1884	Rectal cancer	End colostomy	
W.G. Baum	1879	Proximal colon cancer	Proximal colon cancer	
J. Mikulicz	1903	Colon cancer	multi-stage treatment of colon cancer	Fourth stage: variety of kinds of stomas, wide range of indications
C.H. Mayo W.E. Miles	1904 1908	Rectal Cancer	abdominoperineal extirpation of the rectum with terminal colostomy	
H. Hartmann	1921	Rectosigmoid stenosis	Rectosigmoid resection and end colostomy	
R. Turnbull	1950	introduced the concept of the rehabilitation of stoma patients		
B. Brooke	1952	proposed pulling out the mucous lining of the stump of the ileum and attaching it to the anterior abdominal wall by suture		Fifth stage: stoma surgery gives rise to stoma therapy
Elise Sørensen	1954	The attachable colostomy bag was invented		
Norma Gill	1958	a patient with an ileostomy, operated by Turnbull for ulcerative colitis, became the first professional in providing care to stoma patients		
N. Kock	1969	The technique of creating a “containment” ileostomy was first proposed		
In the early 21st century, with the emergence of sphincter-saving operations, the need for intestinal stomas dropped drastically				

Fernando Botero Angulo (1932-2023)





Preface

An Open Letter to Surgeons from an Ostomate

Kenneth W. Aukett¹

¹United Ostomy Associations of America

Clin Colon Rectal Surg 2017;30:155–156.

When invited to write a preface to this issue in *Clinics in Colon and Rectal Surgery*, I was asked to provide a patient perspective about the holistic impacts of having a stoma. So that the reader may understand my perspective, I have had a stoma for over 40 years. I continue to live a fulfilling, busy, and dynamic life. I am still an active participant in my building maintenance business. As a cofounder of the United Ostomy Associations of America (UOAA), I actively advocate on behalf of ostomy surgery patients regarding quality of life issues.

It is important for the surgeon to thoroughly answer all questions about stomas prior to surgery. Don't gloss over your responses. Small issues to the medical professional can be very big to the patient. I also recommend seeking counsel from a local ostomy support group that is affiliated with the UOAA (www.ostomy.org). There are more than 350 such groups throughout the United States. UOAA is recognized by both the American Society of Colon and Rectal Surgeons and the Wound, Ostomy and Continence Nurses Society.

- “Is there a special diet that must be adhered to?” There is no “ostomy diet” and any restrictions are those dictated by common sense or other medical conditions.
- “What about the clothes I will wear, will they be baggy and lacking in style?” Nope! Designer jeans, no problem.
- “When I enter a room, will people smell me before they see me?” No way. Thanks to today’s ostomy product manufacturers, the unpleasant odors associated with a fecal stoma are a thing of the past.
- “Can I still engage in sporting activities?” Absolutely. Tennis, golf, swimming, running, most certainly. I even have a friend with an ileostomy who is an amateur boxer and another who climbed the Seven Summits, the highest mountain peak on each of the seven continents.
- “Will I be able to return to my job as a policeman or will I be restricted to a sedentary life?” People with ostomies serve on police forces, as firemen, and in the military flying a Blackhawk helicopter; there is really nothing you can’t do!
- “Can I have sex and intimacy?” Sexual activities are indeed possible and a stoma doesn’t necessarily keep a woman from pregnancy and enjoying motherhood.
- “What will my spouse, family, and friends think of me?” People will react to you in the same way you react to yourself ... they will see what you see when you look into a mirror ... if you are upbeat and can go with the flow, then that is the way you will be perceived.

SPECIAL ESA LECTURE 2019

Procedural Surgical RCTs in Daily Practice

Do Surgeons Adopt Or Is It Just a Waste of Time?

Christian E. Oberkofler, MD,* Jacob F. Hamming, MD, PhD,† Roxane D. Staiger, MD,* Philippe Brosi, MD,*
Sebastiano Biondo, MD, PhD,‡ Olivier Farges, MD, PhD,§ Dink A. Legemate, MD, PhD,¶
Mario Morino, MD,|| Antonio D. Pinna, MD,** Hugo Pinto-Marques, MD, PhD,†† John V. Reynolds, MD,‡‡
Ricardo Robles Campos, MD, PhD,§§ Xavier Rogiers, MD,¶¶ Kjetil Soreide, MD, PhD,|||
Milo A. Puhan, MD, PhD,*** Pierre-Alain Clavien, MD, PhD,* and Inne Borel Rinkes, MD, PhD†††✉

Additional Survey Questions Asking for Personal Factors for or Against Adoption of RCT Recommendations

Procedure Implementation Practices*

Reason for implementation of practice

Manuscript of a randomized controlled trial, % (n/N)	66% (86/130)
Assisting live operation, % (n/N)	18% (23/130)
Lecture on new procedure by expert, % (n/N)	12% (16/130)
Surgical video, % (n/N)	4% (5/130)
No change of surgical practice anymore, % (n/N)	0% (0/130)

Reasons not to adopt practice

Doubt validity of methodology, % (n/N)	40% (52/130)
Believe have low clinical relevance, % (n/N)	24% (31/130)
Unknown outcomes considered as unclear risks, % (n/N)	15% (20/130)
Learning curve, % (n/N)	15% (19/130)
Inconvenient new procedural technique, % (n/N)	6% (8/130)
Method not accepted by patients, % (n/N)	0% (0/130)
Fear of cost, % (n/N)	0% (0/130)

Previous Implementations of new practices

Implemented new technique after only video presentation, % (n/N)	46% (60/130)
New technique after only reading a RCT, % (n/N)	55% (72/130)

*General information: more than 1 possible answer.
n/N indicates numerator/denominator; %, percent.

In conclusion, procedural surgical RCTs are still embraced as the highest level of surgical evidence. Nonetheless, they carry a highly variable degree of adoption in daily surgical practice. More emphasis should go to ways to better convince the surgical community of the evidence produced, including modern methods of disseminating RCTs outcomes, corroborating evidence from similar RCTs, and additional tools to evaluate surgical innovations.

(Ann Surg 2019;270:727–734)

IPOD Study: Management of Acute Left Colonic Diverticulitis in Italian Surgical Departments

Massimo Sartelli¹ IPOD study Collaborative Working Group

World J Surg
DOI 10.1007/s00268-016-3800-y

Initial treatment according to WSES staging

	Uncomplicated	Stage 1a	Stage 1b	Stage 2a	Stage 2b	Stage 3	Stage 4
Patients	327 (100%)	263 (100%)	94 (100%)	75 (100%)	47 (100%)	43 (100%)	78 (100%)
No treatment	9 (2.8%)	2 (0.8%)					
Anti-inflammatory therapy alone	6 (1.8%)	2 (0.8%)	2 (2.1%)				
Antimicrobial therapy alone	292 (89.3%)	225 (85.6%)	65 (69.1%)	28 (37.3%)	17 (36.2%)	3 (7.0%)	
Percutaneous drainage			1 (1.1%)	11 (14.7%)			
Laparoscopic lavage and drainage		3 (1.1%)	6 (6.4%)	3 (4.0%)	2 (4.3%)	8 (18.6%)	5 (6.4%)
Open lavage and drainage		7 (2.7%)	1 (1.1%)	1 (1.3%)	3 (6.4%)	2 (4.7%)	
Laparoscopic colonic resection	8 (2.4%)	7 (2.7%)		5 (6.7%)	1 (2.1%)	1 (2.3%)	3 (3.8%)
Open colonic resection	12 (3.7%)	10 (3.8%)	10 (10.6%)	17 (22.7%)	11 (23.4%)	7 (16.3%)	16 (20.5%)
Laparoscopic Hartmann resection			3 (3.2%)			1 (2.3%)	1 (1.3%)
Open Hartmann resection		5 (1.9%)	5 (5.3%)	10 (13.3%)	13 (27.7%)	20 (46.5%)	49 (62.8%)
Paul–Mikulicz exteriorization		2 (0.8%)	1 (1.1%)			1 (2.3%)	4 (5.1%)

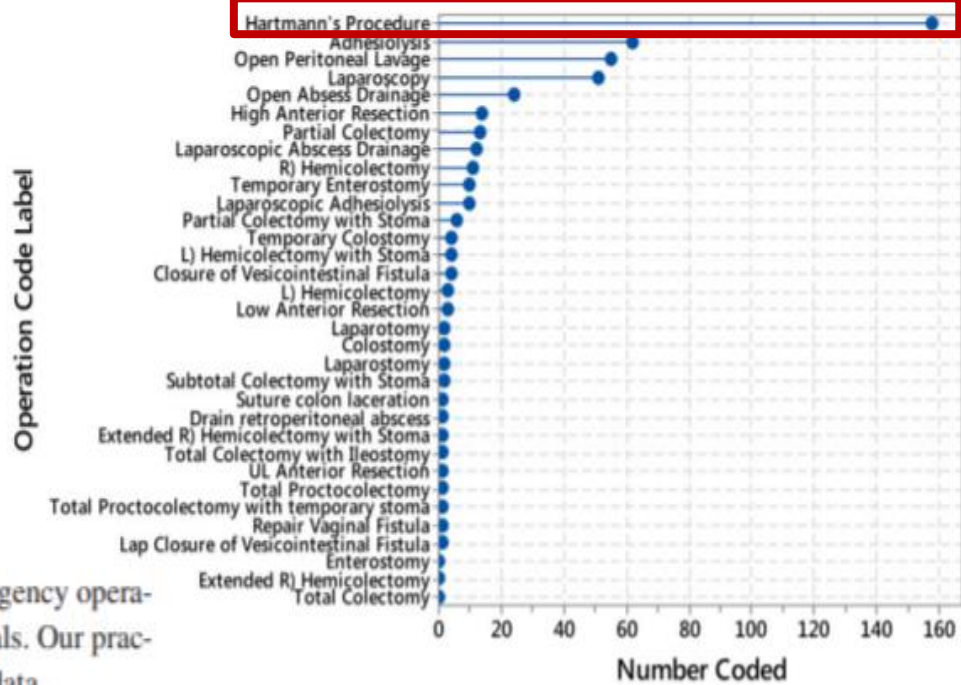
Operative intervention rates for acute diverticulitis: a multicentre state-wide study

Michael K.-Y. Hong,*† Andrew M. Tomlin,‡ Ian P. Hayes*† and Anita R. Skandarajah*†

ANZ J Surg 85 (2015) 734–738

Methods: Coding algorithms designed to increase the yield and accuracy of administrative data were used to find emergency admissions from the Victorian Admitted Episodes Dataset. Eight tertiary referral centres with specialist colorectal services from 2009 to 2013 were studied. Key metrics including the operative intervention rate were measured.

Frequency of Procedure Codes Used in Complicated Diverticulitis 2009-2013



Conclusion: Hartmann's procedure is currently the most common emergency operation for acute complicated diverticulitis in Victorian metropolitan hospitals. Our practice and outcomes can be measured meaningfully using administrative data.



Reduction in Surgical Stoma Rates in Crohn's Disease: A

Population-Based Time Trend Analysis

DR CHRISTOPHER MA

Figure 1. Change in overall surgical stoma formation rates between 2002 and 2011. Annual percent change -5.2% [95% CI: -8.5%, -1.8%].

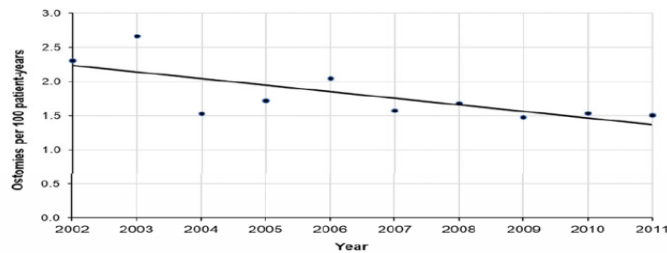


Figure 3. Change in surgical stoma formation rates between 2002 and 2011, stratified by temporary (blue) and permanent (orange) stomas. Rates of permanent stoma formation have been stable (APC 1.0% [95% CI: -4.0%, 6.3%]). Rates of temporary stoma formation have been decreasing (APC -4.6% [95% CI: -7.3%, -1.8%]).

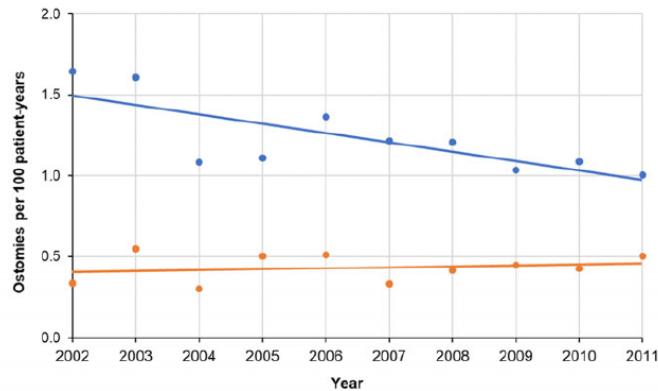
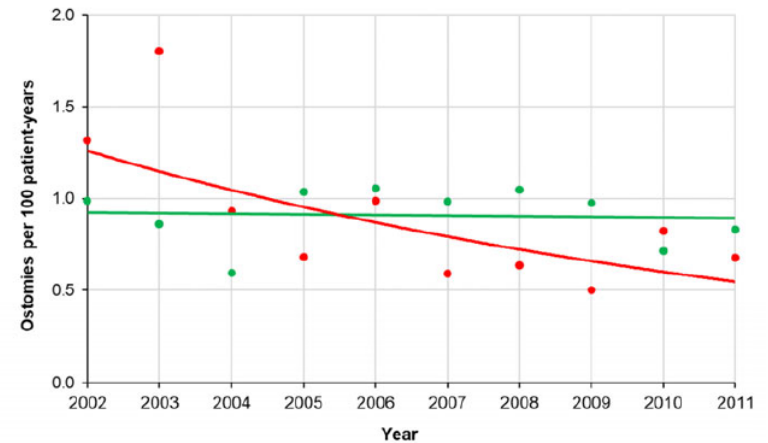


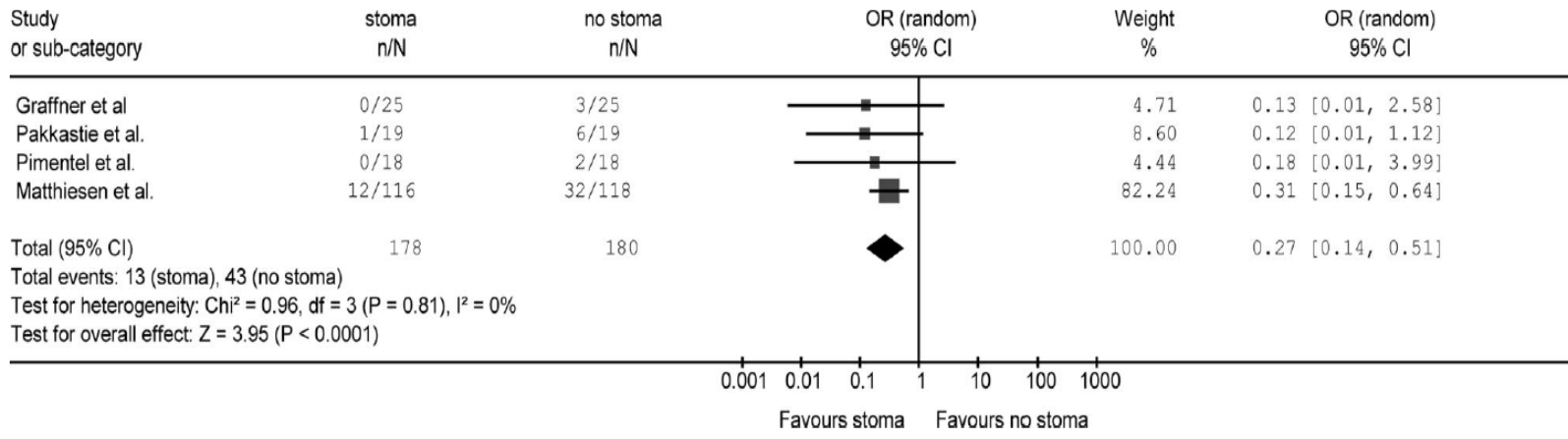
Figure 2. Change in surgical stoma formation rates between 2002 and 2011, stratified by emergent (red) and elective (green) indication. Rates of elective stoma formation have been stable (APC -0.9% [95% CI: -5.3%, 3.8%]). Rates of emergent stoma formation have been decreasing (APC -9.4% [95% CI: -15.6%, -2.8%]).



Systematic Review and Meta-Analysis of the Role of Defunctioning Stoma in Low Rectal Cancer Surgery

Norbert Hüser, MD,

(Ann Surg 2008;248: 52–60)



Conclusion: A defunctioning stoma reduces the rate of clinically relevant anastomotic leakages and is thus recommended in surgery for low rectal cancers.



Permanent Stoma After Low Anterior Resection for Rectal Cancer

Theodor Junginger, M.D.¹

DISEASES OF THE COLON & RECTUM VOLUME 53: 12 (2010)

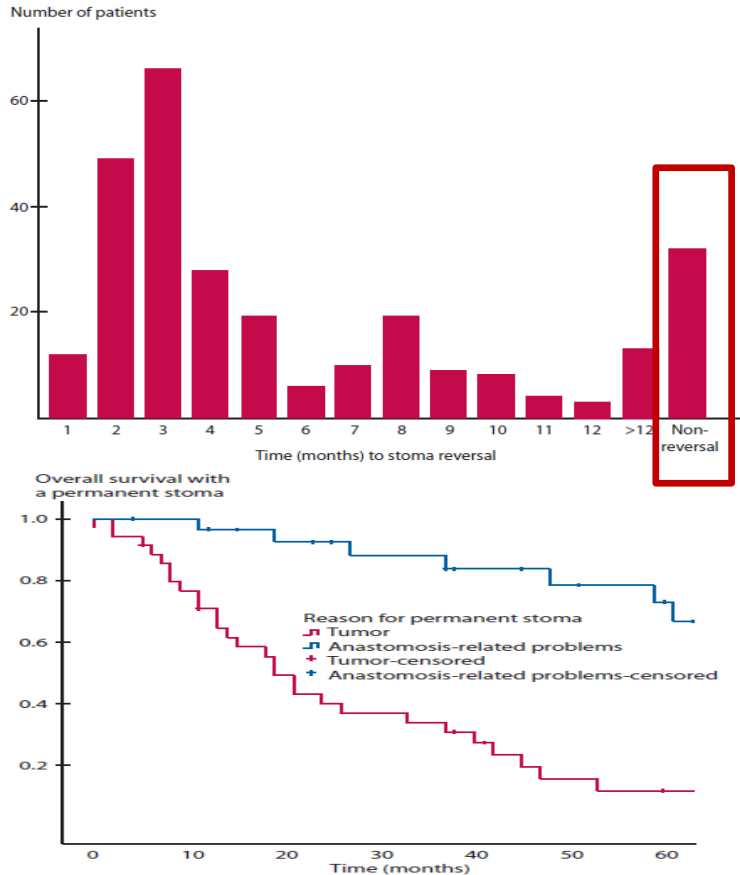


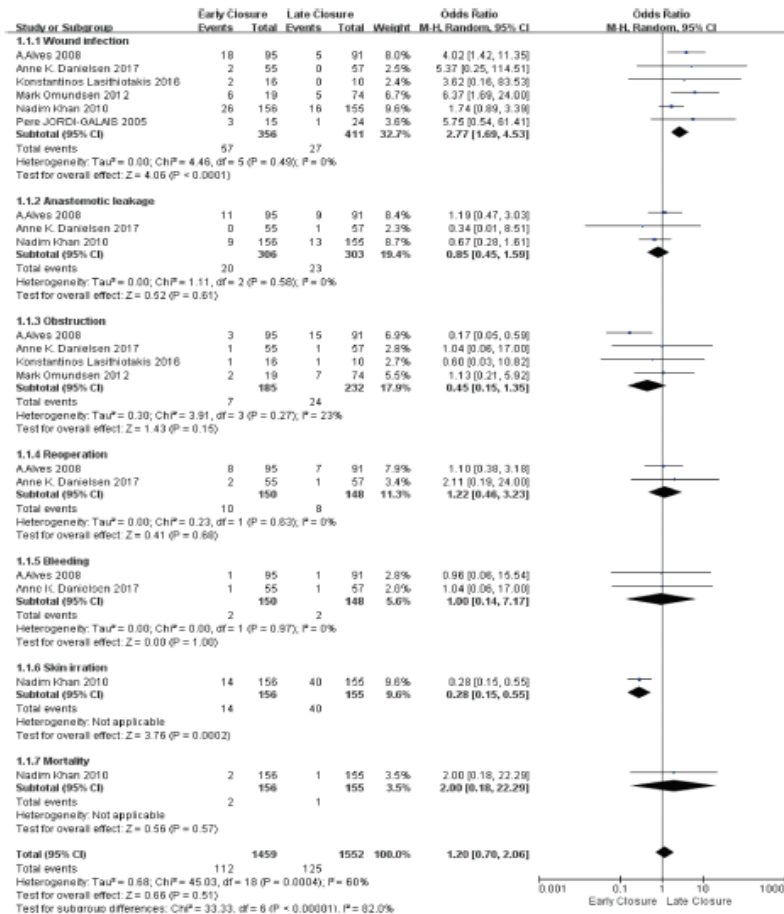
TABLE 4. Multivariate analysis for risk factors for a permanent stoma after LAR

	OR (95% CI)	P
Age	1.032 (0.992; 1.074)	.115
Localization		.377
Middle vs upper third	2.254 (0.603; 8.43)	.227
Lower vs upper third	3.11 (0.625; 15.48)	.166
Complications		<.001
Nonanastomosis-related vs no complications	8.99 (1.86; 43.5)	.006
Anastomosis-related vs no complications	22.4 (8.8; 56.8)	<.001
Tumor stage		.225
UICC II vs 0/I	0.982 (0.38; 2.54)	.97
UICC III vs 0/I	2.132 (0.801; 5.675)	.13
Therapy		.172
Adjuvant R(C)T vs surgery only	2.836 (0.754; 10.67)	.123
Adjuvant CT vs surgery only	0.583 (0.09; 3.796)	.572
Neoadjuvant therapy vs surgery only	2.567 (0.655; 10.06)	.176
Local recurrence	68.5 (22.1; 212)	<.001
Type of anastomosis (coloanal vs colorectal)	1.463 (0.546; 3.922)	.45

LAR = low anterior resection; UICC = International Union Against Cancer; RCT = chemoradiotherapy; CT = chemotherapy.

Meta-analysis of early versus late closure of a temporary ileostomy after proctectomy

Xiaozhun Huang¹,



www.impactjournals.com/oncotarget/

Vol.9, (No.1), Supplement 1, pp: s1027-s1037

CONCLUSIONS

The best available evidence demonstrates that early closure of a temporary ileostomy after proctectomy at 4 weeks shows no significantly increased morbidity, except an increased wound infection rate. No significant differences in the operative time, postoperative hospital stay length, and total hospital stay length for stoma reversal was observed between the early and late closure groups.



Open access

Protocol

BMJ Open Prospective, randomised, multicentre, open-label trial, designed to evaluate the best timing of closure of the temporary ileostomy (early versus late) in patients who underwent rectal cancer resection and with indication for adjuvant chemotherapy: the STOMAD (STOMa closure before or after ADjuvant therapy) randomised controlled trial

Elective vs. Emergency Stoma Surgery Outcomes

Adnan Qureshi^{1*}, Joanne Cunningham² and Anil Hemandas³

Adnan Qureshi, et al.,

World Journal of Surgery and Surgical Research - General Surgery

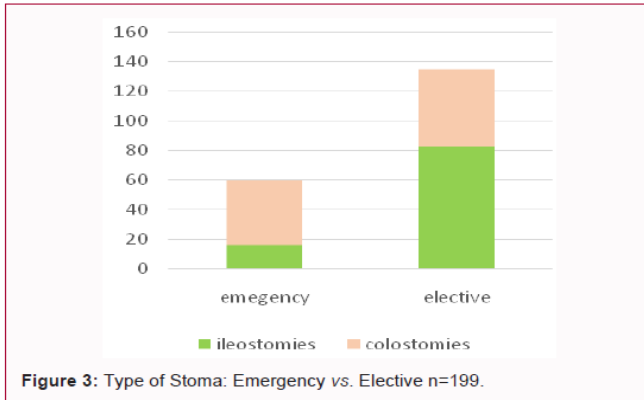


Figure 3: Type of Stoma: Emergency vs. Elective n=199.

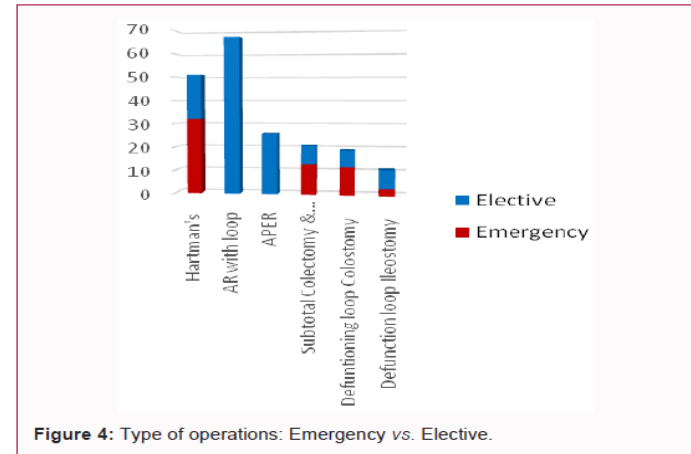


Figure 4: Type of operations: Emergency vs. Elective.

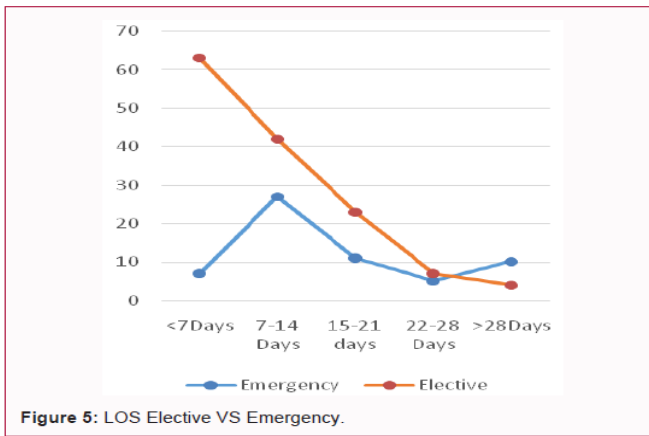


Figure 5: LOS Elective VS Emergency.

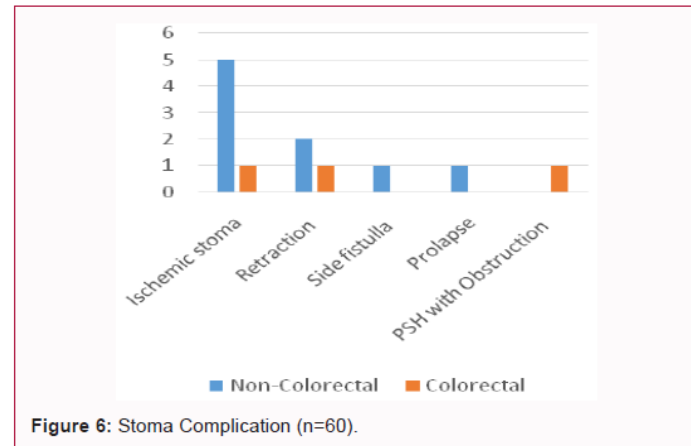


Figure 6: Stoma Complication (n=60).

Le iene - Quentin Tarantino (1992)



28 aa

Politrauma auto contro camion

GCS 15. Abdominal pain

Esami di lab: GB 15.000 Hb 9

Lac 3 BE 1

Prima TC di ingresso=> no blush milza

grado 3 AAST, lacerazione meso

TC total body per peggioramento clinico:
sospetta perforazione ileale e grado 3 AAST
milza (piccolo blush attivo)

Blocco operatorio:

Laparotomia esplorativa + splenectomia +
resezione ileale + ileostomia

Dimesso in 7 gpo

Ricanalizzato a 21 giorni



Current Status of the Prevention and Treatment of Stoma Complications. A Narrative Review[☆]

Mario de Miguel Velasco,

CIR ESP. 2014;92(3):149-156

Table 1 – Rate of Stoma Complications.

Main author	Year	No.	% of complications
Pearl ²²	1985	610	25.9
Porter ²⁵	1989	126	44.0 ^a
Unti ⁹	1991	229	13.1
Londono-Schimmer ²³	1994	203	51.2 ^a
Park ¹⁵	1999	1616	34.0
Saghir ¹⁴	2001	121	67.5
Kairaluoma ¹³	2002	349	12.0 ^b
Arumugam ¹²	2003	97	50.5
Mahjoubi ⁹	2005	330	69.4 ^a
Robertson ¹⁰	2005	408	23.5
Mala ⁷	2008	72	27.0
Nastro ⁴	2010	1216	46.4
Parmar ⁵	2011	192	27.1

^a Only colostomies.

^b Only temporary stomas.

Current Status of the Prevention and Treatment of Stoma Complications. A Narrative Review[☆]

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Table 2 – Classification and Stoma Complication Rate.

% early complications	% late complications
Hydroelectolytic disorders 20–29	Cutaneous 12–43
Cutaneous 6–42	Stenosis 2–15
Mucocutaneous dehiscence 7–25	Parastomal hernia 0–25
Collapse/retraction 3–35	Bad position 8–43
Infection/abscess 2–15	Prolapse 2–25
Necrosis 1–34	
Intestinal obstruction 2–7	
Bleeding 2–3	

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Bleeding 2–3	


Current Status of the Prevention and Treatment of Stoma Complications. A Narrative Review[☆]

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Conclusions

Stoma complications are frequent and compromise quality of life. Many are secondary to stoma construction, and may therefore be prevented through good surgical technique employed by experienced surgeons. The use of meshes reduces the risk of parastomal hernia and the rate of recurrence after repair. The role of the stoma therapy nurse is essential in selecting the stoma site in the pre-operative phase and also in the follow-up phase, to help ostomy patients adapt better and gain independence, and achieve a better quality of life.



Current Management of Intestinal Stomas and Their Complications

Shingo Tsujinaka¹⁾

J Anus Rectum Colon 2020; 4(1): 25-33



Figure 1. Stoma necrosis above the fascia.



Figure 2. Stoma necrosis below the fascia.



Emergency stomas; should non-colorectal surgeons be doing it?

Adnan Qureshi¹, Joanne Cunningham², Anil Hemandas³

Table 1. Diagnosis and type of stoma in the emergency cohort (n=60)

Diagnosis	Ileostomy n=16	Colostomy n=44
Diverticular Perforation	0	17
Colorectal Adenocarcinoma	4	12
Volvulus	2	6
Inflammatory bowel disease	2	0
Ischemia	6	3
Trauma	2	2
Stercoral perforation.	0	4

Table 2. Diagnosis and type of stoma in the elective cohort (n=135)

Diagnosis	Ileostomy n=83	Colostomy n=52
Colorectal adenocarcinoma	65	29
Diverticular Disease	2	18
Ischemic Stricture	1	1
IBD	5	2
Constipation	10	2

Conclusion: Emergency surgery procedures are frequently bowel related. Emergency stoma surgery should not be taken as trivial procedure, non-colorectal surgeons should take advice and assistance from specialist colorectal surgeons for bowel related cases, particularly when a stoma is involved

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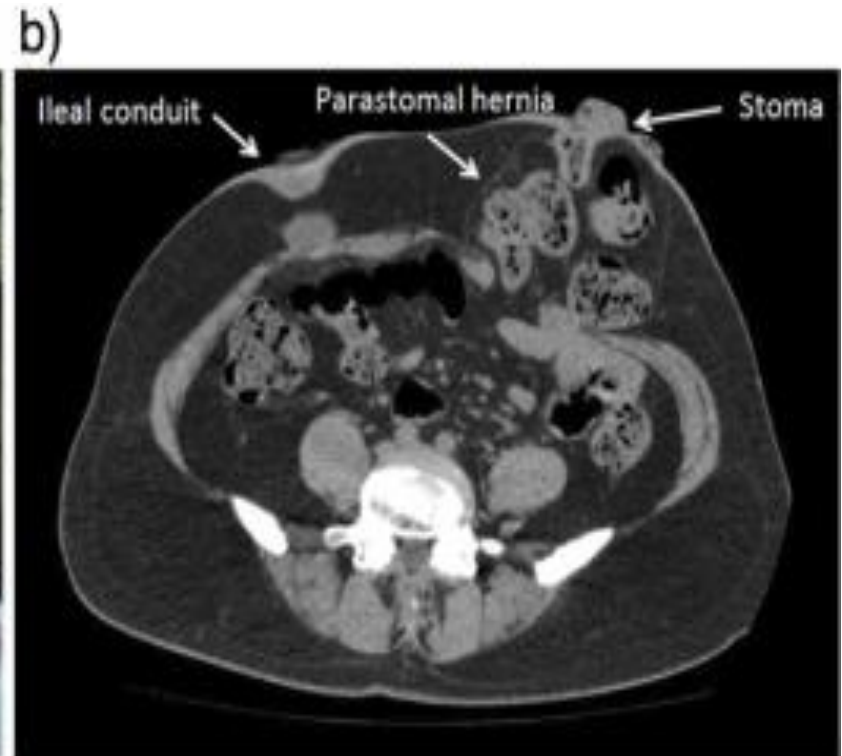
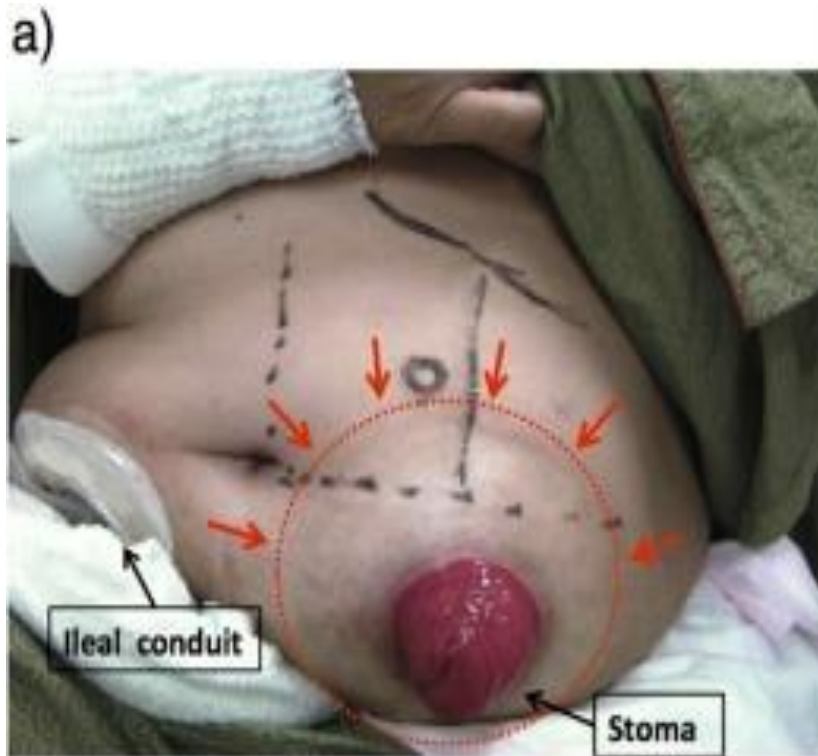


Figure 3. Peristomal pyoderma gangrenosum (PPG) before treatment.

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Principles of Perioperative Patient Management

Preoperative education

Preoperative education enables shorter hospital stay of the patients after stoma surgery due to enhanced recovery after surgery (ERAS)[5]. Preoperative education is provided by nurse specialists, most likely the wound, ostomy, and continence (WOC) nurses. Caregivers of the patient may be invited, if necessary. The content may include the consequences of bowel resection, possible impact of stoma on relationships, sexuality, activities of daily living, anticipated clinical course after surgery, and fundamentals of stoma care and equipment[5].



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Principles of Perioperative Patient Management

Preoperative stoma site marking

The preoperative stoma site is marked to select the optimal stoma location that promotes the patient's independence in stoma care and resumption of normal activities, predicts wear times of pouching systems, and reduces postoperative complications[1,2]. The key points, procedure, and examples of stoma site marking have been detailed previously[2].

Current Management of Intestinal Stomas and Their Complications


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Principles of Perioperative Patient Management

Postoperative education

Patients who undergo stoma surgery need to develop new skills in the early postoperative period, while adjusting to physical changes and new circumstances[1]. The purpose of postoperative education is to acquire skills of self-care and ability to assess stomal/peristomal conditions. However, time for patient education may be limited because of advancements in minimally invasive surgeries and shorter hospital stay with ERAS. In 2016, the WOC Nurses (WOCN) Society published the summary of their consensus conference



SEMINARS IN Oncology Nursing

Vol II, No 4

November 1986

Ostomy Surgery: An Overview of Historical, Current, and Future Perspectives

Bettie S. Jackson and Debra C. Broadwell

SUPPORT GROUPS

Three major support groups, the IAET, the UOA, and the ACS provide professional and peer assistance to people with stomas, regardless of the etiology and whether the stoma is permanent or temporary.

Mettersi insieme è un inizio, rimanere
insieme è un progresso, lavorare
insieme è un successo.

Henry Ford

